

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05207

5222 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Grantsville</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Grantsville, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>/</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>VIRGINIA</u> (Last) <u>BENDER</u>				(Month) <u>May</u> (Day) <u>21</u> (Year) <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 11, 1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Grantsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Stanton</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca VanSickle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214 323254</u>		17. INFORMANT & ADDRESS <u>William Bender, Grantsville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
171X IMMEDIATE CAUSE (A) <u>Carcinoma of the Cervix, advanced</u>						<u>3 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Uremia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19, 1956</u> , to <u>May 21, 1957</u> , that I last saw the deceased alive on <u>May 21, 1957</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ruth Peachey</u>		DATE THEREOF <u>5/23/57</u>		NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>		LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co. Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Paul Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald J. Newman</u>		ADDRESS <u>Grantsville, Md.</u>	
DATE <u>MAY 24 '57</u>							

CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CLERK

18. SIGNATURE OF ASSISTANT CLERK

19. SIGNATURE OF RECEPTIONIST

20. SIGNATURE OF ATTENDING NURSE

21. SIGNATURE OF CHIEF NURSE

22. SIGNATURE OF CHIEF CLERK

23. SIGNATURE OF CHIEF RECEPTIONIST

24. SIGNATURE OF CHIEF INTERVIEWER

25. SIGNATURE OF CHIEF CLERK

26. SIGNATURE OF CHIEF RECEPTIONIST

27. SIGNATURE OF CHIEF INTERVIEWER

28. SIGNATURE OF CHIEF CLERK

29. SIGNATURE OF CHIEF RECEPTIONIST

30. SIGNATURE OF CHIEF INTERVIEWER

31. SIGNATURE OF CHIEF CLERK

32. SIGNATURE OF CHIEF RECEPTIONIST

33. SIGNATURE OF CHIEF INTERVIEWER

34. SIGNATURE OF CHIEF CLERK

35. SIGNATURE OF CHIEF RECEPTIONIST

36. SIGNATURE OF CHIEF INTERVIEWER

37. SIGNATURE OF CHIEF CLERK

38. SIGNATURE OF CHIEF RECEPTIONIST

39. SIGNATURE OF CHIEF INTERVIEWER

40. SIGNATURE OF CHIEF CLERK

41. SIGNATURE OF CHIEF RECEPTIONIST

42. SIGNATURE OF CHIEF INTERVIEWER

43. SIGNATURE OF CHIEF CLERK

BUREAU V. E.

MAY 24 1957

RECEIVED

STATIONER

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05208

166

5223 CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>MARYLAND</u>		STATE <u>W Va</u>		COUNTY <u>Preston,</u> ✓	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Oakland Md,</u>		LENGTH OF STAY (in this place) <u>1 Year,</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kingwood</u>		W Va, <u>85x 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Evans Nursing Home,</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bruce</u> (Middle) <u>Lazell.</u> (Last) <u>Bucklew,</u>				(Month) <u>May</u> (Day) <u>8</u> (Year) <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 22 1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor,</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Preston County, W Va,</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John I Bucklew,</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane Knotts.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>234- 12-8921</u>		17. INFORMANT & ADDRESS <u>Mrs Arnet Gauer, Terra Alta.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Renal failure</u>				W Va. INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-renal Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Senility & Arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Rheumatic Heart Disease</u>							
19a. DATE OF OPERATION <u>4/16X</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 19 50</u> to <u>May 8, 19 57</u> , that I last saw the deceased alive on <u>May 7, 19 57</u> , and that death occurred at <u>11:00 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James E. Smith</u>				DATE SIGNED <u>5/11/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial,</u>		DATE THEREOF <u>May 11/57</u>		NAME OF CEMETERY OR CREMATORY <u>Kingwood Cemetery,</u>		LOCATION (City, town, or county) (State) <u>Kingwood, Preston, W Va</u>	
24. REC'D BY REGISTRAR <u>5/11/57</u>		REGISTRAR'S SIGNATURE <u>Julius A. Roemer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W H Brunning</u>		ADDRESS <u>Kingwood, W Va</u>	

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Illegible]

2. SEX: [Illegible] 3. AGE: [Illegible]

4. DATE OF BIRTH: [Illegible]

5. PLACE OF BIRTH: [Illegible]

6. OCCUPATION: [Illegible]

7. CAUSE OF DEATH: [Illegible]

8. PLACE OF DEATH: [Illegible]

9. TIME OF DEATH: [Illegible]

10. SIGNATURE OF DECEASED: [Illegible]

11. SIGNATURE OF WITNESSES: [Illegible]

12. SIGNATURE OF PHYSICIAN: [Illegible]

13. SIGNATURE OF CLERK: [Illegible]

14. SIGNATURE OF JUDGE: [Illegible]

15. SIGNATURE OF SHERIFF: [Illegible]

16. SIGNATURE OF CORONER: [Illegible]

17. SIGNATURE OF JURY: [Illegible]

18. SIGNATURE OF COURT: [Illegible]

19. SIGNATURE OF STATE: [Illegible]

20. SIGNATURE OF COUNTY: [Illegible]

21. SIGNATURE OF CITY: [Illegible]

22. SIGNATURE OF TOWN: [Illegible]

23. SIGNATURE OF VILLAGE: [Illegible]

24. SIGNATURE OF HAMLET: [Illegible]

25. SIGNATURE OF PARISH: [Illegible]

26. SIGNATURE OF PRESTON: [Illegible]

27. SIGNATURE OF RECTORY: [Illegible]

28. SIGNATURE OF VICARAGE: [Illegible]

29. SIGNATURE OF CHURCH: [Illegible]

30. SIGNATURE OF CHANCEL: [Illegible]

31. SIGNATURE OF ALTAR: [Illegible]

32. SIGNATURE OF PULPIT: [Illegible]

33. SIGNATURE OF SEAT: [Illegible]

34. SIGNATURE OF STALL: [Illegible]

35. SIGNATURE OF CHAIR: [Illegible]

36. SIGNATURE OF TABLE: [Illegible]

37. SIGNATURE OF CUPBOARD: [Illegible]

38. SIGNATURE OF PRESS: [Illegible]

39. SIGNATURE OF CASE: [Illegible]

40. SIGNATURE OF CHEST: [Illegible]

41. SIGNATURE OF BOX: [Illegible]

42. SIGNATURE OF CASK: [Illegible]

43. SIGNATURE OF BUTT: [Illegible]

44. SIGNATURE OF BARREL: [Illegible]

45. SIGNATURE OF HOPKIN: [Illegible]

46. SIGNATURE OF KILN: [Illegible]

47. SIGNATURE OF CRUVE: [Illegible]

48. SIGNATURE OF BURN: [Illegible]

49. SIGNATURE OF STOVE: [Illegible]

50. SIGNATURE OF HEARTH: [Illegible]

RECEIVED

BUREAU Y. R.

MAY 27 1957

RECEIVED

5224 CERTIFICATE OF DEATH

Reg. Dist. No.

05209
769

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Barrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Oakland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppitt Nursing Home				d. STREET ADDRESS Seventh & Alter Sts.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ella Middle May Last Echard				4. DATE OF DEATH Month May Day 21 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1870		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oakland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME George Spiker				14. MOTHER'S MAIDEN NAME Sarah Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hugh Echard		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 1 , 19 56 , to May 20 , 19 57 , that I last saw the deceased alive on May 20 , 19 57 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2570 N. J. St. Oakland, Md. DATE SIGNED 5/23/57							
ACTUAL SIGNATURE E. J. BARNARD M.D.				DATE SIGNED 5/23/57			
PHYSICIAN'S NAME (Type) E. J. BARNARD M.D.				ADDRESS OAKLAND, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Oakland		22d. LOCATION (City, town, or county) (State) Oakland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Balden				ADDRESS Balden Funeral Home Oakland, Md.		24a. RECEIVED BY REGISTRAR DATE 5/23/57	
				24b. REGISTRAR'S SIGNATURE John Rowan			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 1

MAY 27 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5225 CERTIFICATE OF DEATH

Reg. Dist. No.

05210
166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ACCIDENT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN , Middle HENRY , Last FRESH				4. DATE OF DEATH Month MAY Day 2 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/19/1877		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY for others		11. BIRTHPLACE (State or foreign country) ACCIDENT, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN FRESH				14. MOTHER'S MAIDEN NAME ELIZABETH SPEICHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) n o (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 234-12-2891		17. INFORMANT Address MRS. GUY HINEBAUGH, OAKLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UR Em. i 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anteriosclerotic Heart Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 4 wks 4 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 9, 1957 , to May 2, 1957 , that I last saw the deceased alive on May 2, 1957 , and that death occurred at 5:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 West OAKLAND 5-2-57 DATE SIGNED 5-2-57							
ACTUAL SIGNATURE James H. Feaster, Jr.		M.D. James H. Feaster, Jr. M.D.		Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/1957		22c. NAME OF CEMETERY OR CREMATORY Brethre n Cemetery		22d. LOCATION (City, town, or county) (State) Ac ciden t, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE 5/5/57		24b. REGISTRAR'S SIGNATURE Julia C. Brown	

RECEIVED

MAY 10 1957

BUREAU Y. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

5226

CERTIFICATE OF DEATH

Reg. Dist. No.

05211

166

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kiser Nursing Home		e. STREET ADDRESS 85X-3	
3. NAME OF DECEASED (Type or print) First Orval Middle Truman Last Hilborn		4. DATE OF DEATH Month May Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1872
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Repairman		10b. KIND OF BUSINESS OR INDUSTRY B & O R. R. Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 420.0	
17. INFORMANT Kiser Nursing Home		Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis PNEUMONIA DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO 7 years (c) Senile DUE TO 7 years			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-7-57 , 19 57 , to 5-10 , 19 57 , that I last saw the deceased alive on 5-10 , 19 57 , and that death occurred at 3:30A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James H. Feaster, Jr. M.D. 58 St. Oakland 5-12-57			
ACTUAL SIGNATURE James H. Feaster, Jr.		PHYSICIAN'S NAME (Type) James H. Feaster, Jr.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/1957	
22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Reighton		24a. REC'D BY REGISTRAR 5/13/57	
ADDRESS Oakland, Md.		24b. REGISTRAR'S SIGNATURE Julia A. Rogers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED Mr. J. L. R. R.		2. SEX Male		3. AGE 65	
4. DATE OF DEATH Jan 18 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Maryland	
10. OCCUPATION Retired		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY None		15. PHYSICIAN'S SIGNATURE J. L. R. R.	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESSES None		18. SIGNATURE OF REGISTRAR J. L. R. R.	

BUREAU V. S.

JAN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5227

CERTIFICATE OF DEATH

05212

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
c. LENGTH OF STAY IN 1b 32yrs.				d. STREET ADDRESS R.D. #2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #2				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PETER Middle A Last McKENZIE				4. DATE OF DEATH Month 5 Day 2 Year 19 57.			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-30-1887		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Md. Garrett County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis McKenzie				14. MOTHER'S MAIDEN NAME Sarah Garlitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 814-16-7536		17. INFORMANT Mrs. Esco Garlitz, R.D. #2, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 543X Chronic gastritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 2, 1957 , to 5-2 , 19 57 , that I last saw the deceased alive on 5-2 , 19 57 , and that death occurred at 5 A. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H.C. Diehl M.D.				ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED 5/3/57			
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-57		22c. NAME OF CEMETERY OR CREMATORY St. Anne's Cemetery		22d. LOCATION (City, town, or county) (State) Avilton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Burial H. Montmarquet				24a. REC'D BY REGISTRAR Hafer Funeral Home		24b. REGISTRAR'S SIGNATURE DATE 5-4-57 Du Nancy N. Lee	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Figure 1

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

AY 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05213
166

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park			c. LENGTH OF STAY IN 1b 7 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Penn Point - Deep Creek Lake				d. STREET ADDRESS Penn Point Deep Creek Lake		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Calvin Ritchey				4. DATE OF DEATH Month Day Year May 10 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1871		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY Pittsburgh Products Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Ritchey				14. MOTHER'S MAIDEN NAME Mary Khlare			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 170-14-9431		17. INFORMANT Address William J. Ritchey Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 45 min.</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/13/1957		22c. NAME OF CEMETERY OR CREMATORY Everett Cemetery	
22d. LOCATION (City, town, or county) (State) Everett, Penna.							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hebert C. Leighton Oakland, Md.				24a. REC'D BY REGISTRAR DATE 5/12/57		24b. REGISTRAR'S SIGNATURE Julia C. Rogers	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
VITALS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 81

1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05214

5229

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		STATE MARYLAND		COUNTY GARRETT			
CITY (If outside corporate limits, write RURAL OR and give nearest town) VINDEX		LENGTH OF STAY (in this place) 3 1/2 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) VINDEX			
HOSPITAL OR INSTITUTION OR STREET ADDRESS EAST VINDEX				STREET ADDRESS (If rural give location) EAST VINDEX			
3. NAME OF DECEASED (Type or Print) FRANCES (First) MELIE (Middle) SHARPLESS (Last)				4. DATE OF DEATH MAY 25 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 9, 1905		9. AGE last birthday 52 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if HOUSEWORK)		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) GARRETT CO., MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME WILLIAM MARTIN PAUGH				14. MOTHER'S MAIDEN NAME MARTHA SUSAN BARNARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-34-5198		17. INFORMANT & ADDRESS Wm. McKinley Sharpless, Vindex, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
157X IMMEDIATE CAUSE (A) Acute myocarditis						INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Coronary of Pancreas							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) & lived						2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 19 55, to May 25 19 57, that I last saw the deceased alive on May 25 19 57, and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
SIGNATURE <i>Ralph Calandrella</i>		M. D. <i>R. T. Sharpless</i>		ADDRESS (Street, city, town, state) <i>Blaine, W. Va.</i>		DATE SIGNED <i>May 27-57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 28/57		NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		LOCATION (City, town, or county) (State) Mt. Zion, Garrett Co., Md.	
24. REC'D BY REGISTRAR DATE 5/27/57		REGISTRAR'S SIGNATURE <i>R. W. Barrick</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>O. H. Sharpless</i>		ADDRESS Blaine, W. Va.	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF DECEASED: [illegible]
11. SIGNATURE OF WITNESSES: [illegible]
12. SIGNATURE OF PHYSICIAN: [illegible]
13. SIGNATURE OF CORONER: [illegible]
14. SIGNATURE OF MINISTER OF THE GOSPEL: [illegible]
15. SIGNATURE OF CLERGYMAN: [illegible]
16. SIGNATURE OF CHAPLAIN: [illegible]
17. SIGNATURE OF RABBI: [illegible]
18. SIGNATURE OF MINISTER OF THE GOSPEL: [illegible]
19. SIGNATURE OF CLERGYMAN: [illegible]
20. SIGNATURE OF CHAPLAIN: [illegible]
21. SIGNATURE OF RABBI: [illegible]

BUREAU V. 1

MAY 29 1957

RECEIVED

Handwritten notes and signatures at the bottom of the page, including "MAY 29 1957" and "RECEIVED".

5230

CERTIFICATE OF DEATH

Reg. Dist. No.

05216
166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAKE FORD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAKE FORD, GARRETT CO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH JANE TEETS		4. DATE OF DEATH Month Day Year MAY 29 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE-30-1893
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY SWALLOW FALLS	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM SINES		14. MOTHER'S MAIDEN NAME SARAH LEWIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address EARL TEETS, LAKE FORD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteroides Typh 571.1 DUE TO Myocardial heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 days 6 years 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1951 , to 29 May, 1957 , that I last saw the deceased alive on 28 May, 1957 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. E. MARCE M.D.		ADDRESS (Street, city or town, state) Oakland, Md DATE SIGNED 29 May 57	
PHYSICIAN'S NAME (Type) A. E. MARCE MD		OAKLAND Md 29 May 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JUNE-1-1957	22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY	22d. LOCATION (City, town, or county) (State) OAKLAND Md
23. FUNERAL DIRECTOR'S SIGNATURE Emory Baldwin		ADDRESS OAKLAND MD	
24a. REC'D BY REGISTRAR 6/1/57		24b. REGISTRAR'S SIGNATURE Julia Brown	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

CERTIFICATE OF DEATH

BUREAU V. 3.

JUN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5231

CERTIFICATE OF DEATH

Reg. Dist. No. 052176

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>			c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Mt. Lake Park</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weeks Nursing Home</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Theodosia</u> Middle <u>Stump</u> Last <u>White</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1957</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Wainfield L. Stump</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Ellyson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>William J. White</u>		Address <u>Oakland, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>420.0</u> DUE TO (b) <u>Auricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Sclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>years</u> <u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-14</u> , 19 <u>57</u> , to <u>5-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-8</u> , 19 <u>57</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5824 St. Charles Rd. Oakland, Md.</u> DATE SIGNED <u>5-18-57</u> ACTUAL SIGNATURE <u>James H. Feaster, M.D.</u> PHYSICIAN'S NAME (Type) <u>James H. Feaster, M.D.</u> <u>Oakland, Md.</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u>				ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/18/57</u>		
24b. REGISTRAR'S SIGNATURE <u>John A. Boyer</u>				ADDRESS <u> </u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN A. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>St. Louis, Mo.</u></p>	
<p>5. Date of death: <u>May 27, 1957</u></p>		<p>6. Place of death: <u>St. Louis, Mo.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Immediate cause: <u>Myocardial Infarction</u></p>	
<p>9. Duration of illness: <u>2 weeks</u></p>		<p>10. Usual place of abode: <u>Home</u></p>	
<p>11. Name of attending physician: <u>Dr. J. H. Smith</u></p>		<p>12. Name of medical examiner: <u>Dr. J. H. Smith</u></p>	
<p>13. Name of funeral home: <u>None</u></p>		<p>14. Name of cemetery: <u>None</u></p>	
<p>15. Name of informant: <u>John A. Smith</u></p>		<p>16. Signature of informant: <u>[Signature]</u></p>	
<p>17. Name of registrar: <u>None</u></p>		<p>18. Signature of registrar: <u>None</u></p>	

BUREAU V. 5

MAY 27 1957

RECEIVED